



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

HEATH TX 75032

Requestor Name and Address

ROCKWALL-HEATH SURGERY CENTER
6435 SOUTH FM 549 SUITE 101

Respondent Name

TPCIGA FOR RELIANCE NATIONAL INDEMNITY

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-11-3000-01

MFDR Date Received

MAY 5, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was not paid according to the A.S.C. fee schedule."

Amount in Dispute: \$3,065.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated May 19, 2011: "TPCIGA has reviewed this dispute and finds that an additional payment is owed to the provider...An EOB will be submitted to the Division upon completion of the audit."

Respondent's Supplemental Position Summary dated May 25, 2011: "TPCIGA has processed the bill in question according to the Texas Workers' Compensation Fee Guidelines and Article 21.28C. The EOB showing payment is attached."

Responses Submitted by: TPCIGA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2011	CPT Code 63685	\$2,355.95	\$0.00
March 7, 2011	CPT Code 63650 (X2)	\$709.10	\$0.00
TOTAL		\$3,065.05	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31,

2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
- W1-Workers compensation state fee schedule adjustment.
- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

1. Is the requestor entitled to additional reimbursement for code 63685?
2. Is the requestor entitled to additional reimbursement for code 63650?

Findings

1. CPT code 63685 is described as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling."

Per ADDENDUM AA, CPT code 63685 is a device intensive procedure and is exempt from the multiple procedure rule discounting.

Division rule at 28 TAC §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

To determine the MAR for procedure code 63685 is a six step process:

Step 1 gather factors:

Addendum B hospital outpatient prospective payment amount for code 63685 CY 2011 is \$14,743.58.

The device dependent APC offset percentage found in the Addendum B for National Hospital OPPIs for code 63685 for CY 2011 is 86%.

The Medicare fully implemented ASC reimbursement for code 63685 CY 2011 is \$13,816.04.

The CMS City Wage Index for Heath, Texas is \$0.9860.

Step 2 determine the device portion:

\$14,743.58 multiplied by 86% = \$12,679.47.

Step 3 determine the geographically adjusted Medicare ASC reimbursement for code 63685:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$6,908.02 (\$13,816.04/2)

This number X City Wage Index is \$6,908.02 X 0.9860 = \$6,811.30.

Add these two together \$6,908.02 + \$6,811.30 = \$13,719.32.

Step 4 determine the service portion:

Subtract the device portion from the geographically adjusted Medicare ASC reimbursement

\$13,719.32 minus \$12,679.47 = \$1,039.85.

Step 5 multiply the service portion by the DWC payment adjustment factor of 235%

\$1,039.85 multiplied by 235% = \$2,443.64

Step 6 add the service and device portion together to determine MAR.

$\$12,679.47 \text{ add } \$2,443.64 = \$15,123.11$

The insurance carrier initially paid \$13,506.30 plus additional payment of \$1,616.83 for a total of \$15,123.13 for code 63685. As a result, additional reimbursement cannot be recommended.

2. CPT code 63650 is described as "Percutaneous implantation of neurostimulator electrode array, epidural"

Per ADDENDUM AA, CPT code 63650 is a device intensive procedure and is exempt from the multiple procedure rule discounting.

To determine the MAR for procedure code 63650 is a six step process:

Step 1 gather factors:

Addendum B hospital outpatient prospective payment amount for code 63650 CY 2011 is \$4,553.02.

The device dependent APC offset percentage found in the Addendum B for National Hospital OPSS for code 63650 for CY 2011 is 58%.

The Medicare fully implemented ASC reimbursement for code 63650 CY 2011 is \$3,707.45.

The CMS City Wage Index for Heath, Texas is \$0.9860.

Step 2 determine the device portion:

$\$4,553.02 \text{ multiplied by } 58\% = \$2,640.75.$

Step 3 determine the geographically adjusted Medicare ASC reimbursement for code 63650:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$1,853.72 ($\$3,707.45/2$)

This number X City Wage Index is $\$1,853.72 \times 0.9860 = \$1,827.76.$

Add these two together $\$1,853.72 + \$1,827.76 = \$3,681.48.$

Step 4 determine the service portion:

Subtract the device portion from the geographically adjusted Medicare ASC reimbursement

$\$3,681.48 \text{ minus } \$2,640.75 = \$1,040.73.$

Step 5 multiply the service portion by the DWC payment adjustment factor of 235%

$\$1,040.73 \text{ multiplied by } 235\% = \$2,445.71$

Step 6 add the service and device portion together to determine MAR.

$\$2,640.75 \text{ add } \$2,445.71 = \$5,086.46$

Code 63650 is not subject to multiple procedure discounting; therefore, the MAR is \$5,086.46.

The requestor billed for 2 units; therefore, $\$5,086.46 \times 2 = \$10,172.92.$ The insurance carrier initially paid \$9,858.60 plus additional payment of \$314.48 = \$10,173.08. As a result, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	04/25/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.